Meeting Minutes of
The Governor's Council on Behavioral Health
1:00 PM – November 8, 2011

The Governor's Council on Behavioral Health met at 1:00 p.m. on Tuesday, November 8, 2011 at Barry Hall's conference room 126, 14 Harrington Road, Cranston RI 02920.

Members Present: Richard Antonelli, Linda Bryan, Cathy Ciano, Mark Fields, Joseph Le, Bruce Long, Anne Mulready, Fred Trapassi, Neil Corkery, Cosper Reed, Ed Congdon, Sandra DelSesto

Ex-Officio Members Present: Kim Sande, Department of Children, Youth and Families (DCYF); Denise Achin, Department of Education (DOE); Mary Ann Ciano, Department of Elderly Affairs; Louis Cerbo, Department of Corrections (DOC); Craig Stenning, Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)

Guests: Michelle Brophy, Linda Mambro, John Neubaurer, Gina Rivera, Vivian Weisman, Alice Woods, Karen Kanatzar

Staff: James Dealy, Lisa Stevens, Michael Varadian, Deb Varga and Louise Blanchette

Once a quorum was established and introductions were made, Neil Corkery acting chairperson, called the meeting to order at 1:00 p.m. Bruce Lang made a motion to accept the minutes of October 13, 2011. Joseph Lee seconded the motioned. Neil called for a vote to approve the minutes. All were in favor, and the minutes were approved.

Jim Dealy asked guests to sign in and provide email addresses so that they can receive minutes and council correspondence.

Jim Dealy distributed a message from SAMHSA congratulating the states who chose to do a combined behavioral health block grant application this year.

Updates from Council Sub-Committees:

Youth in Transition: Denise Achin, chair of the youth transition subcommittee reported that the group has met and will meet again prior to the next Governor's Council meeting and that a report should be ready to share with the Governor's Council at its December meeting.

Block Grant Committee: Vivian Weisman reported that the committee had met one more time after the block grant was submitted. The Committee noted that planning with a short timeline had been a formidable task, and, at the post-submission meeting, it outlined concerns about the planning process going forward. Vivian said she would like to see this discussed when Rich Leclerc is back. One major concern was how to further develop the portions of the block grants that relate to prevention given the stagnant amount of funding. Neil asked whether prevention included mental health and substance abuse. Vivian said that it did, although up to now funding for prevention had been confined to substance abuse. She asked the group to get any ideas to Jim Dealy. Jim commented that what SAMHSA is asking all the states to do is a major redesign of their behavioral health systems. He said that Rhode Island is ahead of many of the other states in that it decided to do a combined behavioral health block grant. He said that, given the amount of effort that will be required for the next planning cycle, the state needs people who are willing to be part of this planning effort and is grateful for those who read this year's document and gave suggestion and input.

Ann Mulready commented that the Block Grant Committee was started because people recognized that this body wanted to have more input. She said she hoped in future years the timelines would be such that there can be earlier involvement in order to provide more feedback.

Cathy Ciano asked Vivian whether, given that the majority of block grant monies are spent on adults per the state's decision, children's mental health was considered when prevention is spoken of. Vivian replied that children's mental health is important and should be an important part of the planning process.

Linda commented that she does not hear much about the developmental disability population for children and adults in the block grant discussion around prevention. Bruce asked whether there was someone on the council who represented the DD community. Linda said that she has a family member who is developmentally disabled and, in that respect, can represent the community.

Kim said that at DCYF there is an entire unit dedicated to this population and that one of the programs in the state plan that was rolled into the FCCP's was the Project Early Start. This program has been up and running for quite a long time and supports children who may be at risk for developmental disability between birth and age four, as well as children who are at risk for abuse and neglect due to parental mental illness or other. Several members noted the possibility of a gap in services to these children between age four and entry into school. It was suggested that this be addressed through the Global Waiver. Kim said that DCYF is trying to move the upper age limit for these services to six.

Departmental Updates:

DCYF: Kim Sande, representing Director Janice DeFrances, gave an update. RFP's, proposals and two tentative awards are being negotiated for the System of Care Phase 2. The System of Care Phase 1, Family Peer Community Partnerships (FCCPs) continues to do well. Kim asked if Colleen Caron could be on the next agenda to present some data outcomes from Phase 1. DCYF's budget is tight, but the agency is working as best as possible given their budget constraints. Neil asked Kim to explain the two grants that were solicited and what Phase 1 and Phase 2 meant to service recipients. Kim said that Phases 1 and 2 are not grants. The System of Care is a change in the way DCYF does business. It is utilizing natural supports, the national wrap-around philosophy and family team meetings. The department has been changing its approach to how case planning is done for about five years. The FCCPs are in year three which will be completed in January, after which year four will begin. It is an intensive home based program for families who have experienced some type of difficulty and have become involved with the Department but not to a level that the Department has had to take any custody or placement. The FCCP's are preventative in nature, utilizing the wrap-around process to keep families from becoming further involved with the department. They also work with families who have never been involved with the Department. Community mapping and access for families through the Family Court network and other systems besides DCYF is available through Parents Support Network and other vehicles.

Contract negotiations for Phase 2 have begun. Phase 2 includes all of the children who are currently in DCYF care, custody or control. It attempts to work with families, natural supports and community partners, giving the families the tools they need to hopefully get the children home or into less restrictive settings sooner. Kim was asked to identify the three populations that FCCP services. FCCP services children who have a serious emotional disturbance; families that have become involved with

community supports rather than DCYF services and youth coming out of the RI Training School who are not on probation who need supports to avoid the delinquent behaviors that got them into trouble.

Ed Congdon commented that he had attended the homelessness conference and some of the DCFY workshops and he felt a problem area was services gap for children turning 18 or 21 (depending on the program they are involved in) who are "aging out" of DCYF. He said that he felt DCYF was not utilizing the ATR program as much as it should be and questioned why they were not being referred to ATR to help them bridge the gap. Kim responded that DCYF is working with BHDDH for those 18 year olds who have a diagnosable condition. She said she would take this information back to Janice DeFrances and Mike Burke, who is the direct service coordinator.

Jim Dealy asked Kim to talk about DCYF's new System of Care Expansion Grant. Kim passed the question on to Cathy Ciano from PSN. Cathy reported that DCYF had applied for and received the grant from the Substance Abuse Mental Health Services Administration. The grant is for one year, and the goal is to develop a strategic plan for how the System of Care work is going to be further expanded throughout the DCYF system. Planning will be inclusive of financial issues, policies and regulations that will have to change. She said the she is the lead family contact for the grant. The grant is structured with two co-principal investigators on grant; Janet Anderson and Elena Nicolella. She said that Rhode Island is one of few states that have received three System of Care Grants.

Updates from BHDDH: Craig Stenning said that the BHDDH newsletter has been reinvented as a Department wide newsletter that will also go out to the communities. BHDDH is open to submission of material and hopes to produce this newsletter monthly. BHDDH will be on Facebook soon. The Anchor Recover Center will be open all day on Thanksgiving. On December 17th , there will be an all afternoon event at the Anchor Center called "Cookies with Santa".

Health Homes Presentation: Craig Stenning said that the Department's Health Homes proposal has been under review by CMS through the course of two submissions, and it appears that, with the exception of a few minor changes in the State Plan Amendment that, approval is forthcoming. CMS wants to approve it before 11/23, when it would automatically be approved.

Craig said this was the first time CMS and SAMHSA have combined on a program, which has been an advantage for RI because the state has a good relationship with SAMHSA. This initiative, which originates from SAMHSA, offers a 90/10 federal match for eight quarters (2 years, which begin when the program starts. If we added new populations at a later time, the eight quarters would begin for the new populations when they are added. BHDDH's representative at SAMHSA will be Kathryn Power, who was a former director of BHDDH.

A copy of Craig's PowerPoint presentation was distributed to the group. The proposal from CMS was to allow states to develop Health Homes (HH) and to offer a number of services for a population which is at risk for serious health issues. Qualifying definitions of serious health issues were "an individual who has two serious health conditions", "has one serious health condition and is at risk for a second" or "has serious mental illness." He continued that this was a huge step forward for CMS, in that mental illness was being recognized by them as a serious health issue. The population that is currently being serviced by the CMHO's automatically qualifies. Neil asked whether eligibility for Health Homes services encompassed substance abuse generically. Craig said that it does not exclude substance abuse, but that substance abuse is not included generically. A team of about eight people in a partnership

between BHDDH, DHS and the community has met three times per week since this proposal was initiated. Liz Earls has co-chaired the team, and Ian Lang from the Providence Center has also been a member of the committee. The committee will remain in place during the implementation phase.

In addition to the population to be served, and second part of the proposal related to the kind of entities that qualify to be Health Homes. One of the categories of entities named in the legislation is community mental health centers. This fit with the state's idea that we wanted to move towards a system that was managed around the condition of the individual rather than by the requirements of billing or payment systems. We want to treat the person as a whole. A definition of the six service categories listed in the attachment takes each of those services and gives a definition that is appropriate for an individual with mental illness. In talking about comprehensive care management, BHDDH is talking about a treatment plan which is centered on the person as a whole. The individual plan is developed through a psycho-social assessment, which is currently done around behavioral health needs, but will be expanded to include physical health. Care coordination is central to the way the plan is written and implemented. This could be of assistance in a number of areas such as housing, outreach to family members, etc. All of these services are non-clinical treatment services. Clinical services are not included in the mix of services covered under Health Home reimbursement, but care management and care coordination are. The HH's health promotion orientation focuses on getting people to care about their health and the program broadens the focus of treatment beyond clinical mental health issues. It includes substance abuse prevention, health education for family members and a great deal of self management.

The team spent time on how to develop a better transitional care plan for people who may be exiting a hospital or long term psychiatric facility. Each CMHO has designated a hospital liaison that will be part of the team. Another focus of the federal Health Homes initiative which made it attractive was that it fit into SAMHSA's discussion of moving the country toward a more recovery oriented system of care. Some components of HH were already in place in RI before the SPA (State Plan Amendment) was written. BHDDH's SPA includes all individuals who are currently diagnosed with serious and persistent mental illness. All seven of the community mental health centers as well the two specialty community mental health organizations are included in the BHDDH's SPA as Health Homes. CSP clients were notified by a letter that went out on September 1st that they have been auto-enrolled in a HH and they were told they can change HH's if they desire to.

Craig listed the conditions required for the CMHOs to become Health Homes. BHDDH's regulations were amended to require that each CMHO sign a "certification document" agreeing to these conditions. One of these conditions is that, by January 2012, each CMHO must have in place a memo of understanding with local hospitals around transition planning. They will also need to establish contacts, contracts and MOU's with the local health centers. Sandra asked how PCPs in each area will be made aware of the opportunity. Craig said that outreach activity is required as part of the certification and will take place over the next quarter. Three major things that will need to be addressed over the two years are health information technology, outcome measures and evaluation.

The certification document specifies what the Health Home treatment teams will consist of. For each (approximately) 200 clients the project requires a team of 11 ½ FTE's and an average minimum of 600 HH service hours per quarter. The composition of the teams was detailed in the PowerPoint presentation. CMS is requiring that certain information be collected to inform their evaluation of the programs' outcomes.

Craig discussed the payment methodology. The state will receive a 90/10 federal/state match for the program and in turn will pay the CMHO's a proposed case rate of $445 per client per month. All services that look like case/care management will be removed from the current billing system and added to the menu of Health Home services. Services defined as "clinical services" are outside of this rate. Craig noted that this is a bundled rate. Left in were two of the modifiers for the CPST codes; one for substance abuse and one for supportive employment, in order to continue to support and encourage those activities. Although it is a bundled rate, the CMHO's are required to utilize the encounter data system that has been in place for approximately two years. By the end of six months or the first year of the Health Homes program, we will have a better idea of how many of the encounters billed under the bundled rate were done face to face, over the phone or in one area or another. This is not required by CMS, but BHDDH feels it needs to continue to be done in order to have a true assessment of costs. In answer to a question from Sandra DelSesto, Craig said that, as a result of this initiative, there will be a shift from the state to the federal budget of approximately 12 million dollars. Eight quarters of funding are guaranteed. If the program is successful, there is some possibility that funding for the initiative will continue beyond the eight quarters.

Richard Antonelli asked what would happen after the eight quarters. Craig said that there is a possibility that Health Homes would be continued with federal funding, or that some of the savings that will accrue at other departments can at the end of the eight quarters be reinvested at BHDDH, which would make up for the switch back to the 50/50 state/federal match. Discussions around this have been held at the state level, but it is difficult to predict what will happen two years from now.

There were numerous slides which looked at quality measures, as well as some clinical and experience of care measures. Each measure was defined, as well as where the data will come from. During a conference call today, CMS said they were looking at seven core measures, but have given us the latitude to respond by Monday as to whether we will report now, a year from now or not at all. BHDDH's decision will not hold up approval of the SPA.

The last slide detailed the complex evaluation that was required for approval. It appears that RI will be the first state in the country that has applied the Health Homes model to community health organizations and individuals with serious mental illness.

In answer to a question from Ed Congdon about possible closings of some CMHOs, Craig said that he did not think any CMHOs would be closing, but the two organizations are already large umbrella organizations, and that more consolidation may occur to make some Centers more competitive with the larger organizations. An example is the creation of Gateway HC, which consolidated Cranston Mental Health and Mental Health Services of Johnston and Northwestern RI. More recently, South Shore also came under the Gateway umbrella.

Lou Cerbo asked if there would be any restriction on the number of times a client could choose to select another CMHO and how often they could switch. Craig said that this is not expected to be an issue, and that clients could change CMHOs as they wished.

Richard Antonelli asked what treatment standards have been developed. Craig said that, when BHDDH converted to the consumer oriented system of care, some changes were made in standards for RIACT teams and that those remain in place.

Cathy Ciano asked whether there was flexibility in the program model to allow the person being served to identify support members other than the required HH team to participate in case planning and treatment. Craig said that there was.

In answer to a question, Craig said that they have not yet come up with non-Medicaid and Medicaid rates for peer support services. Once this is done, they will be inserted into the initiative.

Ann Mulready asked whether this initiative starts at 18 years of age. Craig said that it begins at 21. She also asked if CEDDARS' programs would be population specific, as well, and whether they would include children with SED. Craig replied that he thought CEDDARS was remaining focused on its current population.

Denise Achin said that CEDDARS' current population includes children from birth to 21 and children with special health care needs as defined by MCH.

The question was raised whether 18-21 year olds could be included in Health Home services. Craig replied that this population was not included in the federal submission and could not be included. Michelle Brophy said that the needs of 18-21 year olds were discussed at the Reaching Home housing conference and that she had agreed to bring this issue to BHDDH. Craig said that a better understanding is needed of how that transition takes place and that the biggest problem is with those 18 -21 year olds who do not have a DCYF social worker to coordinate planning with.. Craig said that OHHS has had a workgroup meeting for several months on this issue.

Cathy Ciano commented that she is often amazed that in Rhode Island, as small as it is that, different agencies are doing the same work, sometimes at cross purposes. She commented that this grant presents a good opportunity for different agencies to work together rather than at cross purposes.

Mark Fields asked what a CMHC's client treatment plan will be called in the Health Homes. Craig said that it is still a treatment plan, but with a broader focus than it previously had. The certification document contains the minimum number of hours, the minimum face to face hours and also a minimum number of service hours that are provided outside of the Health Homes.

Linda Bryan asked if there was going to be a way for providers to have direct feedback into the development of the Health Homes. Craig said that this will become a major focus of many groups and committees, to which the Quality Assurance Unit will provide data. Hopefully, this ongoing discussion will translate into fewer emergency room visits, less hospitalizations, longer life, less health-related compromising issues and others outcomes. The quality of clients' physical health, as well as mental health, should improve.

Craig said that the Governor is asking each Department to replace its existing performance measures with a new set of performance indicators that will measure its success in achieving its core goals and objectives.

New/Old Business: Vivian Weisman informed the group that the next ROSC meeting is scheduled for Thursday, November 17at 10:00 a.m. in room 226 at Barry Hall.

Upon motion being made and seconded, the meeting adjourned at 2:45 p.m.

The next meeting of the Council is scheduled for **8:30 a.m**. **Thursday, December 8, 2011 at Barry Hall in room 126, 14 Harrington Road, Cranston RI 02920.**

Minutes respectfully recorded and written by:

Louise Blanchette
BHDDH

/attachments